8655945739

DEPARTMENT OF HEALTH AND HUMAN SERVICES OTC. PRINTED: 08/27/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B, WING 445314 08/27/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF MORRISTOWN 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 | INITIAL COMMENTS F 000 During investigation of C/O # 25825, #25258, #25956 and #26069, conducted August 2-27, 2010, at Life Care Center of Morristown, no deficiencies were cited for C/O #25825, #25258 and #25956 under 42 CFR PART 483, Requirements for Long-Term Care Facilities. A deficiency was cited at F221 for C/O #26069. F 221 483.13(a) RIGHT TO BE FREE FROM F 221 PHYSICAL RESTRAINTS SS=D What corrective action(s) will be 6-18-10 The resident has the right to be free from any accomplished for those residents physical restraints imposed for purposes of found to have been affected by the discipline or convenience, and not required to deficient practice? treat the resident's medical symptoms. Identified residents involved, performed head to toe This REQUIREMENT is not met as evidenced assessements of all residents on by: Sprecial Care Unit for adverse Based on medical record review, observation and effect (6-16-10), had Social interview, the facility failed to ensure residents were assessed for the use of a restraint before a Services follow-up with individuals gait belt was used as a restraint convenience affected (6-16, 17-10). Immediate device to manage the behaviors for two residents dismissal of associate involved in (#9, #10) of ten residents reviewed. offense. (6-17-10) Education was The findings included: given to all associates regarding Residents Rights and appropriate Resident #9 was admitted to the facility on July reporting of any and all violations 15, 2009, with diagnoses including Dementia and Hypertension. Medical record review of the to administration. (Completed 6-Minimum Data Set (MDS) dated June 27, 2010. 18-10)revealed the resident had short and long-term Education conducted by Exec. Director cend DON memory problems and severely impaired decision-making skills; was easily distracted and had periods of altered perception or awareness of surroundings; had repetitive, anxious complaints and wandering behavior; required limited assistance with bed mobility and transfers; and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

00000040100

00/2//2010 14.40

PRINTED: 08/27/2010 FORM APPROVED OMB NO. 0938-0391

	The state of the s	& MIEDICAID SERVICES			The second secon	OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTI A. BUILDING			(X3) DATE S COMPL	LETED
		445314	B. Win	NG	THE STATE OF THE S	08/	C 27/2010
	PROVIDER OR SUPPLIER RE CENTER OF MOR	RISTOWN		50	EET ADDRESS, CITY, STATE, ZIP GODE IT WEST ECONOMY ROAD ORRISTOWN, TN 37814	1	LAST PAULO
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 221	Continued From pa	ge 1	F2	221	The second secon		W. Andrews State of the Parkets
	revealed, "Alarmi (wheelchair). Check Release every 2 hore Release every 2 hore Release every 2 hore Release every 2 hore Medical record reviet assessments dated 23, 2010, and June alarming clip belt was Medical record reviet 21, 2010, through June resident was able to distances with the ferom the wheelchair Review of a termina 2010, revealed Licer #1, "Asked a CNA (Ophysically restrain a belt to affix to handre several occasions for movement on unit." termination form rev for "Improper restric Review of document termination form dat "I was thinking of ke forward and tilting chemical results as the several results as the	ew of a physician's dated June 1-30, 2010, ng clip belt to w/c k every 30 min (minutes). urs" ew of the restraint December 28, 2009, March 21, 2010, revealed an as in place. ew of nurses' notes dated April une 8, 2010, revealed the move the wheelchair short eet and attempted to stand tion form dated June 17, nsed Practical Nurse (LPN) Certified Nursing Assistant) to resident in w/c using a gait ail in hallway. Asked on or gait belt of CNA to restrict Continued review of the ealed LPN #1 was terminated tion/restraint of resident." tation by LPN #1 on the ed June 17, 2010, revealed, eping resident from leaning hair over forward or backward		i i F c d	How you will identify other residents having the potential affected by the same deficient practice and what corrective will be taken? All residents have the potential be affected by this practice residents who utilize restrates assessed monthly and probable interdisciplinary team (nural MDS coordinators, therapy most appropriate use of residents appropriate use of residents and timely reporting of any and timely reporting of any indiscretions of these. Immorphysical assessment of residential condition, assurance of safet disciplinary action (terminates associates who do not follow policy/procedure for restrain	al to be nt e action ntial to . All ints are by sing, for traint. hire, sociates Rights ediate ent y and tion) to	6-18-10
	hematoma." Medical record revie dated June 17, 2010	on floor and causing w of a Social Worker note revealed, "Follow up with improper use of restraint.					.8

PRINTED: 08/27/2010

		E & MEDICAID SERVICES			FORM	APPROVED. 0938-039
STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	SURVEY ETED
Contract Contract Contract		445314	B. WINC	G	-0.00	C 27/2010
NAME OF I	PROVIDER OR SUPPLIER	ember a constant of the property of the second of the seco		STREET ADDRESS, CITY, STATE, ZIP CO	THE RESERVE THE PERSON NAMED IN COLUMN 2 AS A PERSON	2/12010
LIFE CA	ARE CENTER OF MOR	RISTOWN		501 WEST ECONOMY ROAD MORRISTOWN, TN 37814		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION -DATE
F 221	Continued From page	ae 2	F 22	71		
	Resident demonstration improper application consistent (with) base Interview on August conference room, we Director of Nursing (had a clip alarm in period with the hard investigation to have on the 11:00 p.m., to interview with the Acconfirmed the resided double restraint. Observation on August 1:00 p.m., and the confirmed the resided double restraint.	monstrates no ill effects from plication of restraint. Behavior with) baseline" August 3, 2010, at 2:00 p.m., in the pom, with the Administrator and the ursing (DON) confirmed resident #9 arm in place when up in the und the resident's wheelchair had the handrail" (determined later in the to have occurred on June 15, 2010, p.m., to 7:00 a.m., shift). Continued a the Administrator and the DON a resident had been placed in a sint. On August 4, 2010, revealed the not on the secured unit. Interview 2010, at 11:40 a.m., with the day urse on the secured unit revealed		What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? Education to all associates about proper use of restraints and timely reporting if the appropriate use of restraints is not being followed, focus on resident rights and dignity. Eclucation conducted Eclucation conducted OON.		6-18-10
	p.m., with CNA #1 (o 7:00 a.m., shift) on the 2010, confirmed LPN the gait belt and tie (i Continued interview is belt alarm was in place 15, 2010, when CNA to the handrail using Telephone interview a.m., with LPN #1 revithe 11:00 p.m., to 7:0 "Kept leaning forwardtried to pick spots of (resident) was going	on August 4, 2010, at 3:35 on duty on the 11:00 p.m., to the secured unit on June 15, N #1 instructed CNA #1, "Use (resident #9) to the handrail." with CNA #1 confirmed a clip ace on resident #9 on June A #1 secured the wheelchair a gait belt. on August 5, 2010, at 10:10 evealed on June 15, 2010, on 00 a.m., shift, resident #9, dsaw spots in the floor off floorscared to death to tilt w/c forward and hit interview with LPN #1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445314	B. Wil		The second secon		C 17/2010
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MORRISTOWN				5	REET ADDRESS, CITY, STATE, ZIP CODE 01 WEST ECONOMY ROAD MORRISTOWN, TN 37814	0.41	TOTAL TOTAL
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	confirmed a clip ala not able to remove, the wheelchair was a gait belt. Continu confirmed the resid restraint "a few time. Resident #10 was a January 28, 2010, v. Anemia, Depression Psychosis and Chromedical record revided the long-term memory properties and transfers; and important extensive a and transfers; and imprior one-hundred-extensive and transfers; and imprior one-hun	rm, which the resident was was in place at the same time secured to the handrail using ed interview with LPN #1 ent had been in a double es" but not every night. Idmitted to the facility on with diagnoses including in, Alzheimer's Disease, onic Ischemic Heart Disease, onic Is	F		How the corrective action(s monitored to ensure the def practice will not recur i.e.: quality assurance program put into place? Performance Improvement initiated to address proper restraints in keeping with rights and dignity. Will be reviewed in PI meeting by committee comprised of Me Director, Executive Director Director of Nursing, Assistant Director of Nursing, Nursing Administration, Social Serviciteary, Laundry, Housekeep Staff Development Coordina Started 6-18-10 and ongoing 8-10.	icient what what will be Plan use of esidents dical c, nt g ces, ping,	9-18-10

DICHLIF SHIRL FROMEN'S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/27/2010 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		Printer reconstruction	and the second s	OMB NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445314	B. Wi	NG	The second secon	C 08/27/2010	
	PROVIDER OR SUPPLIER RECENTER OF MOR	RISTOWN		50	EET ADDRESS, CITY, STATE, ZIP CODE 01 WEST ECONOMY ROAD IORRISTOWN, TN 37814	00/2	.172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPERTY.	OULD BE	(X5) COMPLETION DATE
F 221	#1, "Asked a CNA (physically restrain a belt to affix to handr several occasions for movement on unit." termination form rev for "Improper restrict Review of documen termination form dat "I was thinking of ke forward and tilting cl and hitting their heathematoma." Medical record revised ated June 17, 2010 (with) resident concerestraint. Resident conference from improper Observation on Augrevealed the resident anti-tippers in place wheelchair, and a peplace. Interview on August conference room, with conference room, with conference mitted to the harm with the Administrator resident had been place. Telephone interview p.m., with CNA #1 (fon secured unit) conference conference with conference conference place.	Certified Nursing Assistant) to resident in w/c using a gait rail in hallway. Asked on or gait belt of CNA to restrict. Continued review of the realed LPN #1 was terminated tion/restraint of resident." tation by LPN #1 on the red June 17, 2010, revealed, reping resident from leaning hair over forward or backward don floor and causing of a Social Worker note of the revealed, "Follow up visit reming improper use of the demonstrates no adverse or application of restraint"	F	221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/27/2010 FORM APPROVED OMB NO 0938-0391

CENTE	KS FUR WEDICARE	& WEDICAID SERVICES	amade damen	-	describer services and a service servi	OMB NO	0, 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
Taxania Maria Salahan		445314	B. WII	1G	PARCAGER PARCAGE STATE S	08/27/2010		
	PROVIDER OR SUPPLIER RECENTER OF MOR	RISTOWN		501	ET ADDRESS, CITY, STATE, ZIP CODE I WEST ECONOMY ROAD DRRISTOWN, TN 37814		name units main de l'All d'All III d'All	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE	
F 221	Continued interview resident had a pelvi the same time the v handrail. Telephone interview a.m., with LPN #1 c restraint was in place #10"s wheelchair has the restraint was the same than the same t	ge 5two or three times." with CNA #1.confirmed the c posey restraint applied at wheelchair was secured to the on August 5, 2010, at 10:10 onfirmed a pelvic posey se at the same time resident ad been secured to the at times" using a gait belt.	F2	221				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BJYU11

Facility ID: TN3202

If continuation sheet Page 6 of 6